| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 6/16/15 through 6/18/15. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow.<br><br>The census in this 44 certified bed facility was 35 at the time of the survey. The survey sample consisted of 9 current resident reviews (Residents #1 through #9) and three closed record reviews (Residents #10 through #12). | F 000 | | |
| F 280 SS=E | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. | F 280 | **F 280 – Plan of Correction**<br>1) Care plans for the 3 residents affected were updated at the time of survey. — 6/18/15<br>2) 100 % of all Care plans for residents on neighborhood will be reviewed and revised to reflect current updates. — 7/15/15<br>3) Manager or designee to educate staff on the care planning processes and to review and revise care plans as appropriate. — 7/20/15<br>4) 10% audit of resident care plans monthly for three months. Corrective action will be initiated for any variances and findings will be reported to PIRMS/QA/QI. — 7/31/15<br>5) Corrective Action to be complete: 7/31/15 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Amy Grossman, LNHA Director of Continuing Care (Administrator) 7/8/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review, it was determined that the facility staff failed to review and revised the comprehensive care plan for three of twelve residents in the survey sample, Residents #1, #8 and #7.

1. The facility staff failed to review and revise Resident #1's comprehensive care plan with new interventions after three falls.

2. The facility staff failed to review and revise Resident #8's comprehensive care plan for the treatment of depression.

3. The facility staff falled to review and revise Resident #7's comprehensive care plan to address the treatment of a wound infection.

The findings include:

1. Resident #1 was admitted to the facility on 4/19/14 with diagnoses that included but were not limited to: Parkinson's disease, depression, failure to thrive, insomnia, peripheral neuropathy, narcolepsy, urinary tract infections, gastroesophageal reflux disease, and coronary artery disease.

The most recent MDS (minimum data set) assessment, an annual assessment, with an

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assessment reference date (ARD), 4/12/15, coded the resident as being severely impaired to make cognitive daily decisions. The resident was coded as dependent on one or two staff members for all of her activities of daily living except eating where she required extensive assistance. The resident was coded as being incontinent of both bowel and bladder.

The nurse's notes dated, 4/17/15 at 8:32 a.m., documented, "Resident was found sitting on a pillow in front of her recliner. She stated "I slide (sic) down from the chair." Denied hitting her head. Skin intact, denied pain. POA (power of attorney), (name of daughter) notified and note left in NP/MD (nurse practitioner/medical doctor) communication book. Neurocheck (neurological checks) initiated. Resident did not have a quality sleep as she was up most of the time during the night. Scheduled UA (urinalysis), C&S (culture and sensitivity) was not done, unable to get urine. Bladder scan done 68 ml (milliliters) noted. Currently deeply sleeping. Will continue to monitor."

The nurse's note dated, 4/21/15 at 4:40 p.m., documented, "Guest was found lying on the fall mat on the side of her bed facing up toward her left side around 15:55 P.M. (3:55 p.m.). When asked what happened guest was unable to respond. Head-to-toe assessment was done, no injury noted. ROM (range of motion) done without sign of pain, noted a slight redness to back of the heald (sic) and left knee, vital signs are within a normal range."

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The nurse's note dated, 5/29/15 at 6:18 p.m. documented, "Resident found on the floor by her recliner chair, lying on her left side, denied hitting her head but unable to tell how it happened. Head-to-toe assessment done, no injury noted at this time, ROM done, able to move all extremities without signs of pain. POA, (name of daughter) notified and note left in NP/MD communication book. Neurochecks initiated, within normal limit at this time. Will continue to monitor."

Review of the comprehensive care plan, dated, 12/1/14, documented, "Falls: I will need assistance to maintain a safe environment and be free from injury related to injury related to fall." The "Care Plan Approaches to address risks" documented in part, "I need reminders to use my call pad for assistance. I need staff to place my pendant on me when I am out of bed and remind me to use it to call for assistance. I need staff to remind my husband he cannot assist me with my transfers and to use my call pad to call for assistance. I need staff to monitor me frequently for positioning and safe transfers. Ensure I am wearing non-slip shoes with all my transfers. I sometimes awaken early in the morning, please monitor me frequently in the am (morning) and assist me to get up oob (out of bed) if I am awake. Help me toilet when I awaken, before meals and when I call for assistance to the bathroom. Ensure my fall mat is in place when I am in bed." None of the above interventions were dated. Handwritten at the bottom of the care plan documented, "4/16/15 - Found on floor in room, (a circle with a line through in indicating 'no') injuries. 4/21/15 - found on floor in bedroom, (a circle with a line through in indicating 'no') injuries." There were no new interventions

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documented to address either fall. The fall of 5/29/15 was not documented on the care plan.

An interview was conducted with RN (registered nurse) #1 on 6/17/15 at 5:09 p.m., regarding who is responsible for updating the care plan for a change in condition. RN #1 stated, "All staff can add to the care plan. Nurses that receive new orders, like oxygen, should add it to the care plan." RN #1 was asked who updates the care plan with a new intervention after a resident has a fall. RN #1 stated, "The nurses."

An interview was conducted with RN #2 on 6/17/15 at 5:15 p.m., regarding who is responsible for updating the care plan for a change in condition, such as urinary tract infection or falls. RN #2 stated, "Any nurse, the director of nursing or the supervisor."

At the end of the day meeting on 6/17/15 at 5:40 p.m. the fall investigations for Resident # 1's falls on 4/17/15, 4/21/15 and 5/29/15 were requested from the administrator and director of nursing.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 6/18/15 at 9:14 a.m., regarding the facility process followed when a resident falls. ASM #2 stated, "The nurse does an assessment. The nurse completes a 'post fall huddle form' and places it in my box. During the high risk rounds, which are done weekly, we review the falls." When asked who updates the care plan with new interventions, the ASM #2 stated, "The nurses

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address it and put it on the care plan."

The care plan for Resident #1 was reviewed with ASM #2. When asked where the new interventions were located on the care plan for Resident #1's falls on 4/17/15, 4/21/15 and 5/29/15, ASM #2 stated, "No there are no new interventions documented there but we reviewed them in risk meeting."

On 6/18/15 at approximately 11:20 a.m. ASM #2 presented the "High Risk Rounds Meeting Minutes." The notes dated, 4/22/15, documented the resident had had two falls in one week (4/16/15 and 4/21/15). The resident was "symptomatic of UTI (urinary tract infection) and c/o (complained of) hot urine and burning, treated, repeatedly for UTI & ABX (antibiotics). Whenever s/s (signs and symptoms) of UTI is observed as per dtr (daughter). Prior fall care plan in place and consistent. UA urinalysis ordered and obtained. Tx (treated) with abx (antibiotics)." The "High Risk Rounds Meeting Minutes, dated 5/29/15, documented, "Appears presenting signs of symptomatic UTI. UA and C&S pending. Staff to place resident in bed. Monitor for side effects. Currently treated with Pyridium* (used to treat painful urination). Not able probably to stabilize body at tines due to dx (diagnosis) Parkinson's. Continue with treatment as ordered. Plan of care unchange (sic)." When asked if the interventions documented on these forms should be on the care plan, ASM #2 stated, "Yes, it should be."

The facility policy, "Fall Management"

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documented, "Procedure: 6.g. Review care/service plan for appropriateness of approaches and/or modify/add approaches if necessary."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

The administrator and director of nursing were made aware of the above concern on 6/18/15 at12:15 p.m.

*http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682231.html

2. The facility staff failed to review and revise Resident #8's comprehensive care plan for the treatment of depression.

Resident #8 was admitted to the facility on 5/26/15 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease,

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cancer of the larynx, dehydration, renal insufficiency, memory loss and new colostomy.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date (ARD) of 6/2/15, coded the resident on the BIMS (brief interview for mental status) as a "twelve" on a scale of zero to 15, 15 indicating the resident is cognitively intact to made daily decisions. Resident #8 was not coded for a change in mood or having behaviors.

A physician order dated, 6/10/15, documented, "Psychiatry consult, dx (diagnosis) depression."

The psychiatry consult dated, 6/17/15, documented, ""Recently went through stress of placing his wife on the Memory Care Unit (upstairs of the facility building)...He is fully oriented, can recall 3 out of 3 words at 2 minutes, and tell me a current event....He admits (an arrow pointing downward to indicated decreased) mood, energy and initiative."

On 6/17/15 the psychiatrist wrote a physician order that documented, "Buporpion XL * (Wellbutrin extended release) (used to treat depression) 150 mg (milligrams) Q AM (morning)."

Review of the care plan dated, 5/26/15, was conducted. There was no documentation regarding changes in mood, depression. There

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was no documented update to the comprehensive care plan for the new treatment for depression.

An interview was conducted with LPN (licensed practical nurse) #1 on 6/18/15 at 11:39 a.m., regarding who is responsible for updating the care plan with new interventions such as a physician ordered antidepressant. LPN #1 stated, "The nurse who takes off the order should be adding it to the care plan."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 6/18/15 at 11:54 a.m. regarding how the comprehensive care plan is updated for a new medication order. ASM #2 stated, "The nurse that takes off the order should update the care plan at the same time in both the binder (active care plan) and the computer."

The facility policy, "Care/Service Plan" documented, "7. Care/Service plan will be updated by hand in-between completion of the holistic assessments/ care/services plans."

The administrator was made aware of the above findings on 6/18/15 at 12:15 p.m.

3. The facility staff failed to review and revise Resident #7's comprehensive care plan for the treatment of a wound infection.

Resident #7 was admitted to the facility on 4/29/15 with diagnoses that included but were not

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limited to: fractured left hip, pneumonia, stroke, chronic obstructive lung disease, and difficulty walking. Resident #7's most recent minimum data set (MDS), an admission assessment with an assessment reference date (ARD) of 5/6/15, coded the resident as being cognitively intact. Section M - Skin conditions assessed in section M1040, "Other ulcers, wounds and skin problems" documented under E. a surgical wound indicated by an "x" in the box next to surgical wounds.

Review of the nursing notes revealed documented on 5/11/15, "Observed Left hip with blanchable redness and warm to touch. The nurse practitioner was asked to assess Resident #7's incision."

A review of the physician's orders on 5/11/15 documented, "Ciprofloxacin (antibiotic) 250 mg (one tablet) x (times) BID (twice a day) for 7 day (sic) dx (diagnosis) cellulitis (a skin infection)." On 5/12/15 there was a physician order to, "Cleanse with NSS (normal sterile saline), pat dry, apply Tabo (sic), (a wound protectant) cover with Aqunel (sic) foam (a wound dressing) qd (everyday)/PRN (as needed)."

A review of the plan of care dated 5/20/15 was conducted on 6/18/15 at 8:35 a.m. The care plan documented, "Change my wound dressing as ordered and as needed." There was no documentation for the antibiotics ordered by the physician for the wound infection.

An interview was conducted on 6/18/15 at 1 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked to review Resident #7's care plan for documentation of the

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| F 280 | Continued From page 10<br>hip incision and subsequent wound infection treatment orders as prescribed by the physician. ASM #2 was able to locate documentation on the care plan from 5/20/15 for wound dressing changes but not an update from 5/11/15 for the physician's orders to treat the wound infection with antibiotics. ASM #2 was asked if the care plan was to be updated with changes in resident's conditions or plan of care. ASM #2 stated, "Yes they should be updated (about the wound infection)."<br><br>ASM #1, the administrator was made aware of these findings on 6/18/15 at approximately 1:54 p.m.<br><br>No further findings were provided prior to exit. | F 280 | | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to administer oxygen per the | F 328 | **F 328 – Plan of Correction**<br>1) Oxygen therapy for resident corrected to reflect 3L at time of survey. 6/18/15<br>2) Orders reviewed for residents with oxygen. Rounds conducted on residents with oxygen to ensure oxygen therapy is administered appropriately. 6/18/15<br>3) Manager or designee to educate staff on the company procedure for administration of oxygen per physicians orders. 7/20/15<br>4) Weekly rounds of residents on oxygen to be completed initially for two months, monthly thereafter for one month, to ensure residents are receiving appropriate oxygen therapy as per physician orders. Corrective action will be initiated for any variances and findings will be reported to PIRMS/QA/QI . 7/31/15<br>5) Corrective Action to be complete: 7/31/15 | |

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physician's order for one of 12 residents in the survey sample, Resident #6.
The facility staff failed to administer oxygen to Resident #6 per the physician's ordered rate of three liters/minute. Resident #6 was observed multiple times during the survey with oxygen on via nasal cannula and the oxygen flow rate set at two liters/minute.

The findings include:

Resident #6 was admitted to the facility on 5/2/15 with diagnoses that included but were not limited to: fractured thoracic spine, chronic obstructive lung disease and elevated lipids (fats). The most recent minimum data set, a significant change MDS (minimum data set) assessment with an assessment reference date (ARD) of 6/4/15 coded the resident as being cognitively intact. In section O - the resident was coded as using oxygen.

On 6/17/15 at 11:15 a.m. an observation was made of Resident #6. Resident #6 was sitting up in a wheelchair with oxygen on via nasal cannula. The oxygen was set at two liters/minute.

On 6/17/15 at 3:35 p.m. an observation was made of Resident #6. Resident #6 was lying in bed watching the television with oxygen on via nasal cannula. The oxygen was set at two liters/minute.

On 6/18/15 at 8:03 a.m. an observation was made of Resident #6. Resident #6 was awake; the oxygen via nasal cannula was on the resident and set at two liters/minute.

A review of the clinical record revealed a

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| ASHBY PONDS INC | 21160 MAPLE BRANCH TERRACE ASHBURN, VA 20147 |

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physician order for oxygen at three liters/minute per nasal cannula and pulse ox (oxygen) monitoring three times daily starting 5/2/2015.

On 6/18/15 at 8:10 a.m., LPN (licensed practical nurse) #3 interviewed regarding Resident #6's physicians order for oxygen. LPN #3 checked the Resident's orders and stated, "Three liters." LPN #3 was asked at this time to check Resident #6's oxygen flow rate. LPN #3 was observed checking Resident #6's oxygen and then stated, "It's not on three liters it is on two, right now." LPN #3 immediately changed the oxygen setting to three liters. LPN #3 was interviewed about the procedure for checking and ensuring a resident's oxygen rate is set per physician orders. LPN #3 stated, "We check it when we make our first rounds on the resident, I haven't checked on this resident yet. We check periodically throughout the day too." LPN #3 was asked to review the oxygen documentation on the TARs (treatment assessment records). LPN #3 then reviewed Resident #6's TARS and stated, "It's confusing because the TAR says two to three liters and then three to four liters." The oxygen flow rate for the above observations was documented as three liters in the TAR under "the oxygen level."

On 6/18/15 at 9:10 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing, regarding whose responsibility it was to check that the resident's oxygen rate was set correctly. ASM #2 stated, "It's the nurse's responsibility to check the O2 (oxygen), I expect them to check it with their first interaction with the resident and then periodically." A copy of the physician's orders, TARs and policy on following physician orders and oxygen therapy was requested.

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On 6/18/15 at 10:05 a copy of the May 2015 TARs, policies on following physicians orders and oxygen therapy were received from ASM #2, the director of nursing. A copy of the June 2015 TARS and physician's original order dated 5/2/15 for oxygen was not obtained.

ASM #1, the administrator, was made aware of these findings on 6/18/15 at 12:00 p.m.

The facility's policies on oxygen therapy and following physician's orders did not provide a statement as to setting the oxygen level according to the physician's order.

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The stx rights of medication administration also pertain to oxygen administration."

No further information was provided prior to exit.

Oxygen therapy is a treatment that provides you with extra oxygen. Oxygen is a gas that your body needs to function. Normally, your lungs absorb oxygen from the air you breathe. But some conditions can prevent you from getting enough oxygen. You may need oxygen if you have COPD. This information was obtained from the webiste: <http://www.nlm.nih.gov/medlineplus/copd.html> (chronic obstructive pulmonary disease).

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| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility document review the facility staff failed to store food in a safe and sanitary manner.<br>The facility staff failed to store raw chicken in a safe manner and failed to discard two four ounce containers of mixed fruit with expired manufactures use by dates in a refrigerator on the resident's unit.<br><br>The findings include:<br><br>An observation was made of the kitchen on 6/16/15 at 3:10 p.m. accompanied by OSM (other staff member) #2, the food services director. Observation was made of the large walk in refrigerator. A large tray of cooked chicken was observed covered with plastic wrap without an open date. A plastic gallon container, not the original manufactures container was observed with approximately one inch of parmesan cheese and was not dated. Raw chicken was observed in a metal tub covered with plastic wrap and was dated 6/13. Further observation was made of the small freezer in the main kitchen area. An opened | F 371 | **F 371 – Plan of Correction**<br>1) Refrigerator and freezer items identified were immediately discarded. 6/17/15<br>2) 100% of refrigerator and frozen items audited to identify any open items and ensure proper labeling and storage. 6/18/15<br>3) Manager or designee to educate staff on the proper procedures for food storage. 6/19/15<br>4) Daily sanitary rounds to be completed initially for one month, weekly thereafter for three months. Corrective action will be initiated for any variances and findings will be reported to PIRMS/QA/QI. 7/31/15<br>5) Corrective Action to be complete: 7/31/15 | |

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bag of frozen chicken tenders and frozen french fries were observed without a manufactures use by date or date when opened on eilher bag.

On 6/16/15 at 3:20 p.m. an interview was conducted with OSM #2. OSM #2 was asked about dating open foods. OSM #2 stated, "They should be dated, I know they just opened those fries today because we had them for lunch." OSM #2 took the frozen chicken and fries out of the freezer and stated, "This needs to be thrown away." OSM #2 was asked how long raw meat could be in the refrigerator. OSM #2 stated, "I have a guideline outside the refrigerator door." When asked to review the guideline titled, "Food Storage Guidelines, Refrigerated Storage, Max Storage Time" for the expiration date for the raw chicken OSM #2 stated, "It's listed here." OSM #2 pointed to the guideline section titled, "Meats, ground (beef, pork, poultry)" which documented: "After opening/after preparation, (good for) one day." OSM #2 was asked if the raw chicken dated 6/13 observed in the large walk in refrigerator was within the guidelines. OSM #2 stated that the chicken was not within the listed guidelines. A copy of the facility's policy on food handling and a copy of the guidelines for food storage were requested. Copies were received on 6/17/15 at 9:15 a.m. from OSM #2.
The facility's policy titled, " Food Labelling and Dating " and date 5/12 documents, "All food and non-food supplies will be clearly labeled and food items dated." In the section of the policy titled, "Procedure" it is documented under, "2. All opened items or items not in original containers will be covered, clearly labeled, and dated. 4. Frozen prepared foods must be consumed within 24 hours of thawing or discarded."

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| F 371 | Continued From page 16<br>On 6/17/15 at 8:10 a.m. an observation was made of the refrigerator on the resident's unit. There were two four ounce containers of mixed fruit labeled with the "Best by date" of 5/7/15. ASM (administrative staff member) #2, the director of nursing was present and was asked to read the dates on the containers. ASM #2 indicated that the dates were for 5/7/15. ASM #2 was asked if the fruit was still appropriate for consumption. ASM #2 stated, "Let me get (name of the food services manager)."<br>On 6/17/15 at 8:14 a.m. OSM (other staff member) #2, the food services manager, was asked to check the dates on the mixed fruit containers. OSM #2 stated, "They're supposed to check this daily." OSM #2 was asked if the fruit containers should be discarded. OSM #2 stated, "Absolutely." OSM #2 took the containers out of the refrigerator and discarded them. OSM #2 stated, "Let me check with our rep (representative)."<br>On 6/17/15 at 12:30 p.m. OSM #2 provided an email from their food representative dated 3/18/15 titled, "BBE (best before end) of Food Products." The email documented in part, "Food products are assigned a Best Before End (BBE) date at the time of manufacture. A product is guaranteed to meet all of its specifications, quality and safety expectations through the assigned BBE, provided that the product is stored as the recommended storage conditions in the unopened uncompromised original containers."<br>On 6/17/15 at 2:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.<br>No further information was provided prior to exit.<br>ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of these findings on 6/17/15 at | F 371 | | |

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| F 371 | Continued From page 17<br>2:00 p.m.<br>No further findings were provided prior to exit. | F 371 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. | F 431 | **F 431 – Plan of Correction**<br>1) Insulin vial found during survey was discarded. Licensed nurses educated immediately regarding dating of insulin vials when opened.<br>2) A 100% audit of other residents with insulin orders completed to ensure that the vials are dated when opened. Any vials not dated were discarded.<br>3) Manager or designee to educate all licensed staff on the company practices related to insulin dating procedures.<br>4) Audit of all medication rooms and cabinets will be completed to ensure items are properly dated when opened. Audit randomly conducted weekly for four weeks, then monthly each shift for three months. Corrective action will be initiated for any variances and findings will be reported to PIRMS/QA/QI.<br>5) Corrective Action to be complete: 7/31/15 | 6/18/15<br>6/18/15<br>7/20/15<br>7/31/15 |

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, the facility staff failed to label and date a multi-dose insulin vial when opened in one of two medication rooms.

In the post acute care unit medication room a bottle of Lantus insulin (used to treat diabetes)* was available for use and not dated when it was opened and accessed.

The findings include:

Observation was made of the post acute care unit on 6/18/15 at 12:44 p.m. accompanied by LPN (licensed practical nurse) # 3. A medication bottle containing a vial of Lantus insulin was observed to be opened, used and available for use. There was no date observed documenting when the vial was opened. The label documented it was dispensed from the pharmacy on 5/6/15. LPN # 3 was asked how she would know when the vial of insulin was opened, LPN # 3 stated, "You can't tell. The nurse is supposed to write on the label of the vial or the container when she first opened it." When asked how long Lantus insulin is good for, LPN # 3 stated, "30 days."

An interview was conducted with LPN #1 on 6/18/15 at 12:56 p.m. regarding the process staff are to follow when opening a multi-dose vial of insulin. LPN #1 stated, "With any multi-dose vial, the nurse must write on the label or container the date that it was opened." When asked how long Lantus insulin is good for, LPN #1 stated, "It's good for 30 days."

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| F 431 | Continued From page 19<br><br>The facility policy, "Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented, "5. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." The policy, "Medication Management" documented, "Medication Storage: 1. Medications will be stored in accordance with manufacturer's instructions."<br><br>*Vials must be discarded 28 days after being opened. If refrigeration is not possible, the open vial can be kept unrefrigerated for up to 28 days away from direct heat and light, as long as the temperature is not greater than 86°F (30°C). http://www.lantus.com/search-results?query=storage+of+lantus#isianchor<br><br>The administrator was made aware of the above findings on 6/18/15 at 1:54 p.m. | F 431 | | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections | F 441 | **F 441 – Plan of Correction**<br>1) Current infection control log updated to ensure all columns complete, as appropriate. 6/18/15<br>2) Current culture results checked to ensure pertinent information is included on infection control log, as appropriate. 6/30/15<br>3) Manager or designee to educate staff on the company practices related to completion of infection control logs. 7/31/15<br>4) Daily audit of infection control log to be completed initially for one month, weekly audit thereafter for two months, to ensure staff are completing the infection control log accurately. Corrective action will be initiated for any variances and findings will be reported to PIRMS/QA/QI. 7/31/15<br>5) Corrective Action to be complete: 7/31/15 | |

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in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review it was determined the facility staff failed to maintain a complete infection control program as evidenced by incomplete infection monitoring logs from January 2015 through April and the month of June 2015.

The facility infection control surveillance forms for January 2015 through April and June 2015 did not contain documentation indicating if a culture was

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done for multiple infections and did not identify the organisms causing the infections.

The findings include:

On 6/18/15 a review of the facility's infection monitoring log from January 2015 to June 2015 was completed. There were 12 columns on the log: "Resident name; Room number; Date of Admission; Infection Site; Date Infection Identified; Signs/Symptoms; Treatment; Type of organism; Care Plan Updated; CX (culture) sent with a "Y" (for yes) and an "N" (for no) ; Isolation Initiated, "Y" and "N"; Date Resolved."

On the January 2015 infection monitoring logs, eight residents were documented with infections. Of those eight residents, three residents had infections that could have had a culture done or a culture was done but no organisms were documented.

On the February 2015 infection monitoring log, seven residents were documented with infections. Of those seven residents, five residents had infections that could have had a culture done or a culture was done but no organisms were documented.

On the March 2015 infection monitoring log there were eight residents with infections documented. Of those eight residents, three residents had infections that could have had a culture done or a culture was done but no organisms were documented.

The April 2015 infection monitoring log there were five residents with infections documented. Of those five residents, two residents had infections

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that could have had a culture done or a culture was done but no organisms were documented.

On the June 2015 infection monitoring log there were six residents with infections documented. Of those six residents, three residents had infections that could have had a culture done or a culture was done but no organisms were documented.

On 6/18/15 at 12:57 p.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked who was responsible for the facility's infection control plan. ASM #2 stated, "I am." ASM # 2 was asked to explain the infection control plan. ASM #2 stated, "We look at surveillance, if we have an outbreak (of infections) we review the resident's record to look at their symptoms, then we educate staff regarding hand washing. At the end of the outbreak we do a RCA (root cause analysis) to determine if we had any opportunities to prevent it (the outbreak)." ASM #2 was asked how staff would know by looking at the infection monitoring log what organism the resident had that required treatment. ASM #2 stated, "I agree it's (the infection control log) is not complete. I'm tracking it and need to put it in one place." A request for the facility's policy on the infection control plan was requested and received.

A review of the facility's policy titled, "Infection Control Monitoring" and dated 6/30/13, documented under "Procedure: collection of data, 1. Information on a confirmed or suspected infection will be entered on the Infection Surveillance Tracking form by licensed nurse." The facility's policy titled, "Infection Control

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Program" and dated 5/20/12 documented under "Policy: 2. C. Maintain records of outbreaks and/or infections."

On 6/18/15 at 2:35 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Antibiotics are powerful medicines that fight bacterial infections. Used properly, antibiotics can save lives. They either kill bacteria or keep them from reproducing. Your body's natural defenses can usually take it from there. Antibiotics was one of the great breakthroughs in modern medicine. Antibiotics can successfully fight infections that used to be life-threatening, like bacterial pneumonia. But the improper use of antibiotics means that more and more and becoming resistant to this kind of medication. So it is especially important to use antibiotics correctly. This information was obtained from the website: <<http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0072621/>>